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RESPONSIBILITY

versus

COMPULSION

Statement by
THE ASSOCIATION FOR MORAL & SOCIAL HYGIENE

on the proposals for
COMBATING VENEREAL DISEASE
made by the
WORLD HEALTH ORGANISATION

This Statement was originally addressed by the Association for Moral and Social Hygiene in the form of a Memorandum to the World Health Organisation as a comment upon their constitutional powers (adopted at the World Health Assembly, Geneva, July 1948), their Resolutions and recommendations embodying proposals for combating Venereal Disease, and concerning Prostitution, Traffic in Women, the Brussels Agreement of 1924 and the establishment of an Expert Committee on Venereal Infections as an advisory body to the World Health Assembly (A/69 July 16th, 1948).

The Association for Moral and Social Hygiene was founded in 1870 to combat the Contagious Diseases Acts, the English form of the State Regulation of Prostitution. It is the parent (and now the British Branch) of the International Abolitionist Federation, founded in 1875. The Association has had continuous experience and has made a close study of the problem of prostitution and promiscuity and, their concomitant, venereal disease, and of the social and legislative methods of dealing with that disease, not only in this country but all over the world for nearly 80 years. It is therefore able to speak with special knowledge of these subjects in their historical perspective.

THE ASSOCIATION FOR MORAL AND SOCIAL HYGIENE
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A.M.S.H. STATEMENT ON THE PROPOSALS OF THE WORLD HEALTH ORGANISATION FOR COMBATING VENEREAL DISEASE

The Powers and Scope of the World Health Organisation.

Under Article 2 the scope of the World Health Organisation, which should be concerned solely with specific health matters, is extremely wide and ill-defined in some clauses.

For instance, Article 2 (i): "to promote, in co-operation with other specialised agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene" gives the World Health Organisation power to deal with matters, which, though they affect health, cannot be considered to be the specific function of a World Health Organisation.

Article 2 (1): "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment" is even wider in scope and it would seem that powers 'to foster the ability to live harmoniously' could be defined to cover any and every activity concerned with social relations, and could overlap those of other United Nations Councils and Commissions.

The World Health Organisation recommendations to Governments of member states are "subject to conditions within their countries", but it is essential that Regulations of the World Health Organisation under Articles 21 and 22 should be carefully scrutinised by Member States and repudiated within the specified time should they conflict with the national policy which has been adopted as suitable for the conditions of any particular country.

The Unique Aspect of Venereal Disease.

Venereal Disease stands in a class apart among the contagious or infectious diseases. Unlike all other such diseases, its contagion and its prevalence do not primarily depend upon general social conditions, or accident, or misfortune. These depend upon the social conduct, the individual action of each and every individual whom it afflicts (save in a very small minority of cases). It has, then, two separate aspects. There is the purely medical, the presence in the human body of *spirochaeta pallida,* and with this aspect doctors and venereal disease specialists are called upon to deal. The other aspect may best be called the social-moral aspect, the social conduct which spreads the disease. This concerns individuals and society as a whole. The great majority of in-

fections are acquired through promiscuous sexual behaviour. Those innocently infected (e.g. husbands, wives, children), are usually so infected because their partners or parents have exercised their sexual function with irresponsibility. Any method of control, as apart from medical treatment, must, to be efficacious, be considered in relation to its effect on the individual and the community. Any legislation, national or international, which directly or indirectly obscures the social and moral problems involved, tends to increase the irresponsibility which leads to the spread of venereal disease, however good may be the medical technique used in the cure of the disease itself.

The long experience of the Association for Moral and Social Hygiene has led the Association to state the following principles:—

(1) In that department of legislation which is concerned with sexual morality, the Association for Moral and Social Hygiene maintains the responsibility of the adult individual (unless legally declared insane or mentally deficient). This responsibility has no meaning unless he or she retains right of control over his or her body.

(2) All laws and regulations must apply equally to all persons, and not only to certain classes of persons.

(3) Promiscuity, infidelity and casual sex behaviour in men or women, though anti-social, cannot be controlled by law. Prostitution, if unaccompanied by third party exploitation, gross public indecency, or debauchment of minors, is equally unamenable to control by law. These are matters for education, both in relation to individuals and to public opinion.

The proposals and recommendations of the World Health Assembly for the control of Veneral Disease are examined here in the light of these principles

RECOMMENDATIONS OF W.H.O.

1. *That Governments take—subject to the conditions in their countries—preventive, curative, legislative, social and other measures necessary for Venereal Disease control, particular attention being paid to the following*:

1. (i) *Notification of primary and secondary syphilis, declaration of sources of infectious contacts, contact-tracing.*

Notification.

The compilation by Departments of Health of statistics of those examined or treated for venereal disease in clinics is useful and necessary, but notification by name or number of persons suffering from any venereal disease is not desirable. Venereal disease is not comparable with other notifiable diseases in that the great majority of persons who are, or think they may be, infected, have personal or family troubles which are inevitably associated with the fact that they have contracted venereal disease. For all practical purposes it may be said that venereal disease is spread by promiscuous sexual intercourse. Even the person

who contracts it innocently, e.g. wife or husband, has the unhappiness of knowing that the partner has almost certainly been unfaithful. It is obvious, therefore, that persons infected, or fearing infection, need special assurances of secrecy to persuade them to come for the essential early examination and treatment. Compulsory notification by name or number means that this assurance cannot be given. It is the first step towards compulsory treament, with publicity and legal punishment for failure to take or continue treatment. Reports from countries with compulsory notification show no better results, and in some cases worse, than those without it. We append a statement on the figures for venereal disease in some countries which already have compulsory notification.

Declaration of sources of infectious contacts.

Does this mean that it is proposed to make it compulsory for a patient to declare the source of infection? If this is so, we point out that it cannot be done. No compulsion can make a patient speak the truth, even if he or she knows it. The disease does not declare itself immediately, and men and women leading promiscuous lives cannot with certainty name the source of an infection. The encouragement of secret denunciation of supposed contacts leads to false (deliberate or mistaken) denunciations, with grave injustice and damage to those named, who have no power of redress. Such a system of protected informers leads to the "tracing" and harrying of suspected promiscuous girls and women on the flimiest description or identification. This system inevitably creates discrimination even if in theory it appears to apply equally to both sexes. The few "contacts" traced, and the fewer actually treated, (experience shows that many "contacts" of the irresponsible type, disappear again as soon as traced), do not make up for the moral degradation implicit in a compulsory system. For example, the innocently infected wife or husband does not mend a marriage by denouncing the married partner. The denunciation of an alleged source of infection, with the knowledge that compulsory measures can be used against that person, further demoralises the character of the denouncer.

The reasonable and private questioning of venereal disease patients as to whom they may have infected or the possible source of their own infection is very valuable. Such patients can be encouraged to approach these persons and tell them how and where to go for examination; but this must be voluntary, and completely detached from any hint of compulsion. It has, in this country, been very successful, where the experiment has been tried. Social workers in venereal disease clinics can also help if the system is non-compulsory and confidential; but under compulsion such social workers become agents, armed with the threat of police action and publicity, in a hunt for alleged promiscuous persons, generally women. This, we maintain, is scarcely the function of highly trained Health Visitors and other social workers. The fact that this work of compulsory contact-tracing is often done with tact and from a desire to help does not invalidate criticism of the system.

National and International Contact-Tracing.

(See page 4 regarding *National* contact-tracing). What does *International* contact-tracing mean? The only efficacious system of contact-tracing would be the compulsory examination of every person leaving a country, and at each frontier. This would be impossible and the public would not submit to it. This proposal can, therefore, only mean in practice that names or descriptions of persons alleged or known to be defaulters from treatment are to be sent round from one country to another, should these persons leave their own. The technical difficulties of this would seem to be insuperable, but morally also it is indefensible. Such "contact-tracing" would lead to the limitation of the movements of suspected persons. It would not be difficult to use this proposal politically. It has a strong totalitarian tendency. Who will these "contacts" be? Will the infected or alleged infected commercial traveller, a member of Government committee or commissions, or representatives of social organizations, be pursued, threatened with the police and compulsory hospitalisation, whatever his or her moral character? This is highly unlikely. Their work is necessary, or their money is useful to the countries in which they travel. What is evidently contemplated is the circulation, internationally, of lists of prostitutes, or women alleged to be infected or, by their known or supposed way of life, likely to become infected. On arrival in a country women on these lists could be forcibly examined and, if diseased, forcibly detained in hospital till declared to be non-infectious. No woman who was, however, the mistress of an influential man would be found on these lists. Therefore, international contact-tracing, when examined from the practical point of view, seems difficult to distinguish from a new international system of State Regulation of Prostitution, the heart of which was, and is, the physical examination of women to render them "safe" for illicit sexual intercourse.

1. (ii) *Systematic Pre-marital and Pre-natal Examination.*

Does "systematic" here mean "compulsory", for both men and women? Does it mean that, if a medical certificate is not forthcoming, a marriage licence can be refused? The Association for Moral and Social Hygiene is opposed to any national or international *compulsory* pre-marital or pre-natal examination. This is a matter for education and the development of personal responsibility; not a field for compulsion. The value of such examination and the responsibilities of marriage and parenthood, can and should be put before men and women by educational means, but compulsion in this field is an infringement of personal responsibility and an impertinence. The already irresponsible will live together without marriage if a medical certificate on either side presents difficulty, and there is wide scope for corruption of officials. Experience of the German eugenic laws suggests how evil is the power to forbid a marriage on such grounds as these. Such a power cannot safely be entrusted at any time to any individual or group. Again we realise that the motive behind this recommendation is a good one with which

we should all agree, namely, the prevention of the birth of syphilitic children. We maintain, however, that the means suggested by the World Health Assembly will not achieve the desired result in the long run.

The *compulsory* pre-natal examination of women is legally inadmissible. A man or woman has the right, under English Common Law, to refuse bodily examination. Examination of the sexual organs, without consent, is an indecent assault. If there is compulsion, and a woman refuses pre-natal examination, what is the *final* sanction? It must be prosecution preceded by a police action, and either forcible examination in a hospital from which she cannot escape, or agreement to examination under threat of such action. Having again in mind the precedent set by German (and certain other) eugenic laws before the war, it would seem that following on the power of *compulsory* pre-natal examination for venereal disease further power over the persistently recalcitrant woman might be demanded. For instance, compulsory sterilisation of women who refused to take treatment for venereal disease, especially those who produced illegitimate children, might be demanded, with power to have "therapeutic" abortion compulsorily performed.

Once the control of the individual over the body is removed, and consent for any interference with the body declared unnecessary, these things become possible, and in fact probable.

Compulsory examination on threat of police action is a most undesirable method, physical and psychological, of dealing with a pregnant woman. All nations should do all in their power to provide the best possible pre- and post-natal care for mothers and children and to offer this under a voluntary system. There is no objection to Wassermann tests as part of ante-natal routine if the mother has the right of refusal. Compulsion and threats, however good the motive, will end in keeping women away from the free maternity clinics, and so delay the essential early treatment of the syphilitic pregnant woman.

1. (iii) *Comparative Study of antigens and serodiagnostic methods in syphilis on the national and international plane.*

This is obviously a suitable medical field for international study and co-operation.

1. (iv) *Establishment of optimum standards of treatment and of making such treatment available to all; with special reference to the importance of preventive treatment of syphilis in pregnancy.*

This is unobjectionable if it means exchange of knowledge of medical methods, and the provision of free and easily available treatment. It is not clear whether the second clause ("with special reference" etc.) refers back to Paragraph 1 (ii) dealing with systematic pre-natal examination. If so, objection to the use of compulsion in this field has already been recorded.

1. (v) *Compulsory treatment of persons suffering from communicable Venereal Disease and compulsory hospitalisation of those who refuse to submit to treatment.*

This, the logical conclusion of all the rest (secret denunciation, contact-tracing, compulsory notification), reveals the dangers inherent in the whole compulsory system, as put forward by the World Health Assembly. Who decides who is to go into these detention hospitals? Is there any appeal? The Association for Social and Moral Hygiene points out that under the proposals of the World Health Organisation:—

(1) The powers of doctors and police become almost unlimited.

(2) Infectious persons can be sent for indefinite periods to detention hospitals, without trial and without appeal. Grave abuse is possible and, indeed, probable.

(3) Wage earners (particularly those with dependents) who contract venereal disease will not be forced into hospitals and kept there indefinitely, nor will men in general promiscuous or otherwise, in civilian life, be subjected to such methods. They would not submit to it. The respectable married woman with venereal disease is unlikely to refuse treatment, if conditions make it possible for her to take it. Even if she defaulted, it would be impossible to send her to a detention hospital for an undefined period. Public opinion in any nation of moral and political maturity would not tolerate such procedure. The recommendation must then, in the main, be aimed at the known or suspected promiscuous women or girls with venereal disease, who are to be subject to indefinite sentence, without trial and without appeal. This is exactly the condition that obtains under State Regulation of Vice, which encourages promiscuity and the venereal disease associated with it, by establishing in practice a different sexual moral standard for men and for women, with the enforced examination and treatment of promiscuous girls and women. Even if it were applicable, and actually applied to men and women equally, it is objectionable because, as has been already said, it gives arbitrary power to officials, allows incarceration without trial, and takes away the basic human right of control over the body.

(4) Medical knowledge in any sphere is constantly changing and developing. New methods in venereal disease treatment are now being tried, and it is known that such methods can be physically dangerous to certain persons. It is quite right that new methods should be tried, but there should never be any treatment, especially by methods of which little is known of the ultimate effects, unless the patient willingly consents to its use. Without consent, physical examination is an assault, and examination of the sexual organs, in men and women, is an indecent assault. Persons who are incarcerated in hospitals for compulsory treatment are in the position of being compulsorily experimented upon, a system which, under the Nazis, was condemned by the civilised world. The aim and motive of the World Health Assembly is doubtless curative and remedial, and not coldly experimental, but acceptance of these pro-

posals would mean that the door is open to experimentation on compulsorily detained and helpless persons. As John Stuart Mill pointed out, in 1879, in relation to this very problem, "It seems to me that we ought not to assume, even supposing that no case of abuse has been found out as yet, that abuses will not occur. When power is given which may easily be abused, we ought always to presume that it will be abused, and although it is possible that great precautions will be taken at first, those precautions are likely to be relaxed in time. We ought not to give powers liable to very great abuse and then presume that these powers will not be abused." The influence exercised by the medical profession, with its traditions of confidence between doctor and patient, and its humanity, will not be increased by these proposals, nor by the earlier proposals regarding compulsory contact-tracing, hospitalisation, etc., in which secrecy and confidence can have no place.

2. RESOLUTIONS OF W.H.O.

(i) *That consultations be held with United Nations and with other international organizations combating prostitution, traffic in women and children, etc., particular attention being paid to the following*:

"The abolition of legal recognition and toleration of prostitution and the rejection of prostitution as a means of livelihood.

This matter would not appear to come within the scope of the World Health Organisation. The Social Commission and the Economic and Social Council of the United Nations are concerned with it. Here is an example of the misuse of the wide scope given to the World Health Organisation by Article 2 of the Constitution.

However, these proposals must be examined. If "the abolition of legal recognition and toleration of prostitution and the rejection of prostitution as a means of livelihood" means the abolition of all State systems for the toleration or recognition of prostitution, the Association for Moral and Social Hygiene is in entire agreement. But it is not clear what is meant by "the rejection of prostitution as a means of livelihood." Prostitution is an undesirable means of livelihood, but what does the resolution mean? Who rejects it? What is the definition of "means of livelihood"? Who proves, and how, that it is used by any person as a means or partial means of livelihood? Does the clause apply to male prostitutes? Is it based on the practice of some countries, where food cards are only issued to persons working at an approved trade? It can, in practice, only mean that any person practising prostitution will be guilty of a punishable offence. This is unacceptable as a dangerous legal tenet, open, as experience shows, to gross abuse, corruption and injustice. Prostitution and profligacy, in both men and women, are morally indefensible, but can only legally be proved and punished when there is third party exploitation for gain, degradation of minors or those with the status of minors, or gross public indecency. Private manifestations are outside

the province of law. Here education and the inculcation of moral standards can alone avail.

2. (ii) *The desirability of making all traffic in prostitution a criminal offence.*

This proposal will meet with universal agreement if "by a third party, for gain" is added after "prostitution". This makes such traffic a definable and legally provable offence, nationally and internationally.

Nevertheless, this is not a matter for the World Health Organisation. Tolerated Brothels and methods of State Regulation of Vice form a focus for the dissemination of venereal disease, and it would be valuable if the World Health Organisation would state this as a medical reason for its opposition to all forms of traffic in prostitution. But it does not state this. It seems to concentrate in this and the next recommendation on the social problem of prostitution, *per se*, concerning itself with the conduct of a minute number of prostitutes (it is minute compared with the total population in any country) as though the prostitute were the main problem. The conduct and beliefs of the mass of individual men and women in any country is the cause of prostitution and this is surely beyond the scope of an organisation for world health.

2. (iii) *The importance of social and economic measures in the fight against prostitution, including the improvement of standards of living, re-education, rehabilitation and assistance from agencies concerned with the moral and social aspects of the problem.*

Social and economic measures in the fight against prostitution are of importance, but it is doubtful whether actual evidence exists that a general rise in the standard of living affects the incidence of prostitution. What is essential is that women should be assured of economic independence and adequate pay, for there is evidence that this affects the amount of prostitution. The question of re-education and rehabilitation, (presumably, from the context, of prostitutes) is a matter for national consideration. Laudable as is such work, it does nothing of itself to resolve the real social evil. If all the prostitutes in one decade were "rescued" would not others, meantime, have filled the gap? While proposals such as certain of the World Health Assembly proposals encourage, however unintentionally, a double standard of morals, a constant succession of prostitutes, or promiscuous women, will replace those who are being re-educated and rehabilitated.

3. *That measures be taken for the revision and expansion of the provisions of the Brussels Agreement of 1924 with a view to their incorporation into international regulations for the control of the spread of Venereal Disease.*

The Brussels Agreement of 1924, concerning the provision of Venereal Disease treatment, in the signatory States, for merchant seamen or watermen, without distinction of nationality, has been of the utmost value and most successful. This system has been voluntary and the treatment, in most countries, free. The extension of such a scheme, to cover all travel-

lers, who may wish to take advantage of it, would be admirable. But this Resolution (3) must be read in relation to other Recommendations of the Report, e.g. 1. (v) (Compulsory Treatment and Hospitalisation). Objection has already been raised to these proposals, and these objections hold good unless it is specifically stated, in Resolution 3, that any such extension or revision of the Brussels Agreement of 1924, does not include provision for compulsion.

4. *That the Executive Board be instructed to establish during its first session an expert committee to be called "The Expert Committee on Venereal Infections of the World Health Assembly", with the following terms of reference : To act as an advisory body to the World Health Assembly.*

It is of great importance (especially when Article 2 is considered) that any expert committee should consist of persons from various countries, and who have knowledge and experience of the different approaches to the social treatment and control of venereal disease. A problem of such varied aspects cannot properly be dealt with by a body representing almost entirely the medical and administrative point of view.

TO SUM UP:—

(1). Many of the World Health Assembly proposals have in them the danger of the creation of an expert caste of persons, medical and police, who will attempt, under legislation or regulations, to control the conduct of individuals in matters which are not properly susceptible to legal process. Nor will the application of such penal sanctions be, in the long run, profitable. On the contrary, help (both medical and social) should be available, under a voluntary system, to all who wish to take advantage of it; and education and propaganda should call attention to such help.

(2). Many of the proposals for *international* control are unworkable. Even as part of *national* action, such compulsory measures, undesirable in themselves, must in practice prove impossible to administer.

(3). It is difficult to read the World Health Assembly Report, in relation to venereal disease, without receiving a general impression that a new penal code is to come into being which would make this sickness an offence, to be dealt with on lines analagous to those used in the treatment of crime.

FINALLY, we emphasise the fact that the Association for Moral and Social Hygiene has, since its foundation, constantly pressed for *constructive* measures, namely the provision of free, voluntary and confidential treatment for all persons who may require it; and better social conditions for the armed forces and merchant seamen (including better barrack accommodation, and better recreational facilities during periods of leave). In earlier days State provision, in the British Isles, for the treatment of civilians, was confined to compulsory treatment for prostitutes. The Association for Social and Moral Hygiene, and other far-sighted societies and individuals, urged that treatment should be made

available to all members of the public who wished to take advantage of it, and the free, voluntary, and confidential system was at last introduced in 1916 (the compulsory treatment of prostitutes having been abolised in 1886). The Association for Moral and Social Hygiene continues to press for more clinics, with longer hours, consideration of rural and industrial difficulties, the extension of social work in connection with clinics, and education both short-term (in the necessity for treatment and the nature of the facilities offered), and long-term (in general social and moral values).

The statistics given in the British Minister of Health's Annual Reports prove, beyond doubt, the outstanding success of the system and the growing degree to which the public has co-operated. The success achieved by the voluntary system justifies its further extension in this country, and its adoption elsewhere.

We suggest that the choice for Member States is between a penal system of compulsion and coercion, with all its attendant evils and abuses, and a constructive system of facilities for widespread free, voluntary and confidential treatment, coupled with a wise educational programme. The Member States have to decide whether, in order to force the examination and treatment of a few irresponsibles, they are prepared to open the door to grave injustices, to create precedents for unwarranted interference with the rights of the individual, to apply laws to special classes of persons, and to place immense and unchecked power in the hands of executives. These are the hall-marks of the totalitarian methods which the United Nations are committed to oppose.

We now ask the World Health Assembly to consider the constructive, and in practice, successful alternative to their proposals, namely the free, voluntary and confidential system, applied without exception, and to lay this alternative before the Member States.

APPENDIX I

A comparison between the results obtained by Compulsory and Voluntary measures for the treatment of Venereal Disease as shown by certain official figures

In comparing the merits of the compulsory versus the voluntary system of venereal disease treatment the most reliable method is necessarily a comparison of pre-war figures, particularly when these show long-term results, e.g. Great Britain 1916 onwards (Voluntary system) and Sweden and Denmark 1918 onwards (Compulsory system).

SCANDINAVIA (Compulsory) versus GREAT BRITAIN (Voluntary)

In 1938 the Ministry of Health of Great Britain published a detailed Report of the results of official enquiry into the results of Anti-Venereal Measures in certain Scandinavian countries and Holland.

This Report shows: as to the incidence of syphilis: (page 119).

Voluntary system

Holland	1.06 per *ten thousand* of population	
England and Wales	1.7	„
Scotland	1.8	„

Compulsory system

Sweden	0.67	„
Denmark	1.6	„
Norway	1.5	„

At first sight the figures for the countries having a Compulsory system give the impression of better results. But this, in reality, is far from being the case. Sweden has a population of from 6 to 7 millions only: less than the population of London. It has only two ports of considerable size—Stockholm and Gothenborg. The rest of the small population is scattered through smallish towns and over wide and sparsely populated country districts. Great Britain, on the contrary, has those conditions which are favourable to a high incidence of venereal disease, namely a large population of some 50,000,000, density of population, and a large number of important seaports—Glasgow, Leith, London, Liverpool, Cardiff, Southampton, Hull, Grimsby, etc., and great industrial cities such as Manchester and Birmingham. When these facts are taken into consideration it becomes obvious that the figures for syphilis incidence in Great Britain of 1.7 per ten thousand of the population show a far better actual result than do the figures for Sweden (0.67) and those for Denmark (1.6) —a country with a total population of some three million. Holland, like Great Britain, adhered to the Voluntary method of dealing with Venereal Diseases. The outstanding (but unexplained) results of this enquiry showed that Holland alone had had a great decrease in *Gonorrhoeal* infections.*

In its Conclusion the British Ministry of Health Report mentioned above stated:

> "Considering that in the countries employing compulsory treatment and in those which rely on a voluntary system the degree of success in reducing the incidence of syphilis and the relative failure in gonorrhoea are broadly similar, compulsory treatment does not seem to us to be a major factor influencing the results of the anti-venereal measures in the countries where it is employed."

Is Contact Tracing useful?

In this connexion we draw attention to the statement made in the British Ministry of Health Report on contact tracing in Stockholm: (page 63).

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*In *Sweden*, though it was a neutral country, the compulsory system broke down during the War and was incapable of dealing with war-time problems of venereal disease.

"We would draw attention to the high proportion of reported sources of infection which remain untraced, *notwithstanding the assistance of the police.* In 1931 police assistance was invoked in 130 cases, of which 83 were untraced, and in 1934 175 cases, of which 107 were untraced."

If the success of contact tracing in a small city such as Stockholm (and this with the help of the police) is negligible in its results, no value can be attached to "national and international" contact tracing.

Is contact tracing, plus special measures against prostitutes and procurers, plus a compulsory medical examination useful?

In connexion with its enquiry in Denmark, the British Ministry of Health Report states:

"Under Section 10 of the Act of 1906 a person charged with prostitution or procuration or with infection of another person can, if he or she consents, be submitted to a medical examination at the instance of the police. If consent is refused the police can obtain an order of the Court for a compulsory medical examination.

In 1936, 379 medical examinations were undertaken at the instance of the morality police in Copenhagen . . . in 11 cases only was the person concerned a man, and 5 of these were found to be suffering from venereal disease . . . Of the *368* medical examinations of women . . . *64* resulted in a diagnosis of venereal disease."

Such deplorable results in a city as small as Copenhagen prove indubitably that an international system of contact tracing can only result in the re-imposition of a compulsory examination of selected and suspected women, similar to the system of the State Regulation of Prostitution, and that the results from the point of view of either health or morals will be bad.

AUSTRALIA, NEW SOUTH WALES.

Pre-War.

Writing on the Notification of Venereal Diseases in July 1937, Dr. Douglas White, M.D., stated:

"In Australia (Medical Journal, Australia, May 16th, 1936) the New South Wales Report for 1934 is not optimistic. Some medical practitioners failed to comply with the Regulations, defaulters failed to be traced owing to false names and addresses or failure to notify change of residence; it is feared that if prosecutions for failure were always undertaken many more would give false information to the doctor. In the upshot, the chief recommendations are for more education for the public and for more adequate facilities for treatment. These are exactly what a voluntary system seeks."

War Years

The following figures (1942-1946) were made available by the Director of Social Hygiene:—

Under a war-time compulsory system:

6,911 persons were notified as sources of infection. Of these 63% were not traced.

Of 2,045 examined 38% showed no evidence of disease.

Under 20% of the 6,911 originally notified came under treatment for venereal disease.

In spite of such facts and figures Australia is now taking steps to intensify the compulsory system in all States, although evidence shows that the system is failing, and—an exceedingly bad social factor—the compulsory measures are used mainly against girls and women.

UNITED STATES.

The Association for Moral and Social Hygiene is indebted to the United States Department of Public Health for figures showing:—

a. rates *per thousand* of Venereal Disease in cities.

b. rates *per thousand* of Venereal Disease in States.

c. prevalence of syphilis in first million volunteers and selectees, *per thousand.*

The United States of America have in many of their States various forms of compulsion, and, in addition, repressive police action against prostitution, prostitutes, the amateur "pick-up" and "good-time" girl. The other side of this problem—male demand—appears to be largely ignored.

Here are the rates for venereal disease as supplied by the American State Department:—

a. *Per thousand* population in cities: Syphilis 4.9 per thousand. Gonorrhoea 2.9 per thousand. (1942).

b. *Per thousand* population in States: Syphilis 3.72; Gonorrhoea 1.67. (1942).

These rates compare very unfavourably with the British rate of 1.7 and 1.8 per *ten thousand* of the civilian population.

The rate for the first million selectees and volunteers was 45.2 per *thousand*: these were men coming from the civilian population and entering the first army drafts.

Table 2 gives figures for statistics for syphilis in various *cities,* for instance:—

	Rate *per thousand*
Chicago	21.5
Philadelphia	41.7
Cleveland	25.3
Birmingham, Ala.	142.8
Rochester, N.Y.	10.6

The rate for negroes is often extraordinarily high: and we submit the figures for white persons only among this first million selectees and volunteers from various *States.*

	Rate *per thousand*
Connecticut	6.1
Michigan	11.2
North Dakota	5.9
Florida	46.8
Pensylvania	14.7
Washington	16.7

It will be seen that, when every allowance is made for the fact that in Britain, as elsewhere, more men are infected by syphilis than are women, the U.S.A. figures, under systems of compulsion, are, at their lowest, so much higher than the British rate as to throw grave doubt on the efficacy of U.S.A. measures.

We append the full venereal disease rates in Great Britain from 1925-1946 (Report of the Minister of Health for the year ended 31st March, 1947). These figures are for the Civilian population only. Figures for the Forces are not yet available. These Tables show a consistent decrease in the syphilitic rate for both men and women up to the War years. And of the greatest importance is the persistent and remarkable increase in the number of persons coming voluntarily to Clinics suspecting they may have venereal disease, who, in fact, prove to be uninfected.

There can be no exact comparison between one country and another: climate, customs, moral standards, etc., differ from country to country. But we suggest that an objective view of the above facts and figures, covering various countries, can only lead to the conclusion that, wherever applied, the compulsory system has not been conspicuously successful, and that far greater success has attended a well applied voluntary scheme.

Copies of this Statement can be obtained from the Office of the Association for Moral and Social Hygiene (price 6d. each)

APPENDIX II

TABLES RELATING TO VENEREAL DISEASE : ENGLAND AND WALES.

From Report of Minister of Health for year ended 31 March, 1947
Number of cases (in all stages) dealt with for the first time at any Centre

Year	*Syphilis*	*Soft Chancre*	*Gonorrhoea*	*Total V.D.*	*Other than V.D.*	*Total Attendance*
Males						
1925	11,782	1,048	24,398	37,228	13,384	1,248,157
1926	12,118	1,070	25,535	38,723	14,269	1,500,074
1927	12,393	986	28,195	41,574	16,192	1,621,409
1928	12,051	1,053	30,425	43,529	17,959	1,794,205
1929	11,538	1,202	31,810	44,550	17,970	1,958,095
1930	11,967	1,244	32,217	45,428	19,724	2,119,257
1931	11,285	1,042	29,310	41,637	19,838	2,251,710
1932	11,032	845	28,179	40,056	20,745	2,322,982
1933	10,738	826	29,169	40,733	20,918	2,396,696
1934	9,615	876	28,787	39,278	23,639	2,488,538
1935	8,596	1,011	27,506	37,113	23,605	2,474,531
1936	8,224	880	28,137	37,241	23,393	2,457,595
1937	8,069	824	29,250	38,143	24,263	2,446,730
1938	7,832	889	27,947	36,668	26,081	2,218,584
1939	7,273	827	24,811	32,911	24,324	1,587,111
1940	7,093	887	21,057	29,037	20,005	1,170,412
1941	7,790	1,017	20,572	29,379	20,476	1,065,114
1942	8,529	969	17,956	27,454	22,302	1,071,664
1943	8,790	773	18,215	27,778	36,868	1,082,427
1944	7,667	628	16,629	24,924	34,123	973,810
1945	8,134	589	21,280	30,003	42,110	912,571
1946	13,803	994	36,912	51,709	70,239	1,279,743
Females						
1925	7,385	27	6,120	13,532	7,287	470,991
1926	7,133	21	6,416	13,570	8,082	507,989
1927	7,553	20	6,809	14,382	8,705	558,298
1928	7,090	28	7,810	14,928	9,492	628,544
1929	6,586	22	7,798	14,406	9,595	646,122
1930	6,916	17	7,939	14,872	10,960	697,938
1931	6,827	20	7,697	14,544	11,402	741,051
1932	6,461	29	7,677	14,167	11,586	786,192
1933	6,029	22	8,583	14,634	11,223	855,627
1934	5,838	10	8,199	14,047	12,672	918,462
1935	5,565	16	7,732	13,313	12,625	924,147
1936	5,128	29	7,715	12,872	13,231	902,733
1937	5,165	15	7,787	12,967	14,002	895,841
1938	4,986	15	7,746	12,747	15,182	900,747
1939	4,605	11	6,489	11,105	14,684	723,455
1940	4,226	21	5,882	10,129	12,881	597,321
1941	4,972	20	7,314	12,306	15,068	593,223
1942	6,542	27	8,413	14,982	20,190	704,076
1943	7,960	32	10,043	18,035	34,681	868,097
1944	8,251	28	10,646	18,925	38,566	916,116
1945	8,508	29	11,603	20,140	41,524	911,974
1946	10,075	34	10,431	20,540	35,475	864,682

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